

REVIEW ARTICLE

Gender dysphoria in childhood

Jiska Ristori^a and Thomas D. Steensma^{b,c}

^aDepartment of Experimental, Clinical and Biomedical Sciences, Careggi University Hospital, Florence, Italy; ^bDepartment of Medical Psychology, VU University Medical Centre, Amsterdam, the Netherlands; ^cCentre of Expertise on Gender Dysphoria, VU University Medical Center, Amsterdam, the Netherlands

ABSTRACT

Gender dysphoria (GD) in childhood is a complex phenomenon characterized by clinically significant distress due to the incongruence between assigned gender at birth and experienced gender. The clinical presentation of children who present with gender identity issues can be highly variable; the psychosexual development and future psychosexual outcome can be unclear, and consensus about the best clinical practice is currently under debate.

In this paper a clinical picture is provided of children who are referred to gender identity clinics. The clinical criteria are described including what is known about the prevalence of childhood GD. In addition, an overview is presented of the literature on the psychological functioning of children with GD, the current knowledge on the psychosexual development and factors associated with the persistence of GD, and explanatory models for psychopathology in children with GD together with other co-existing problems that are characteristic for children referred for their gender. In light of this, currently used treatment and counselling approaches are summarized and discussed, including the integration of the literature detailed above.

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Introduction

Children can vary in the extent to which they show gender role expressions, behaviours, interests, and preferences. For most children these expressions are largely congruent with their experience of being male or female – their gender identity – and in line with the gender assigned at birth. This is in contrast to children who experience gender dysphoria (GD). These children show extreme and enduring forms of gender nonconforming/gender variant behaviours, preferences, and interests because they do not identify with their birth-assigned gender. Because of the incongruence between their assigned gender and experienced gender, these children may experience clinically significant distress and are consequently often in need of clinical attention (American Psychiatric Association, 2013).

Although there has been much opposition against diagnosing GD in prepubescent children, primarily due to the stigmatizing effect of having a mental disorder (e.g. Drescher, 2013), the condition is included in the current edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) (American Psychiatric Association, 2013) as well as in the *International Classification of Diseases* (ICD-10; World Health Organization, 1992). The World Health Organization

(WHO) is, however, in the process of revising the tenth version of the ICD; but instead of removal of the childhood diagnosis the terminology will most likely be changed from ‘gender identity disorder of childhood’ into ‘gender incongruence of childhood’ (Drescher, Cohen-Kettenis, & Winter, 2012).

According to the DSM-5, a diagnosis of GD of childhood can be made if a child experiences a marked incongruence between one’s experienced/expressed gender and assigned gender, of at least 6 months’ duration, as manifested by six out of eight criteria. One *sine qua non* criterion must be the experience of a strong desire to be of another gender or an insistence to be another gender. In addition to this, there are two criteria focusing on anatomic dysphoria; a dislike of one’s sexual anatomy and the desire for primary/secondary sex characteristics of the experienced gender. In addition there are five behavioural criteria. The behavioural criteria concern the preference for cross-dressing; adopting cross-gender roles in fantasy play; a strong preference for toys, games and activities of the other gender; a preference for playmates of the other gender; and a strong aversion or rejection of typically gender congruent roles, interests, preferences and behaviours. Furthermore, the condition is associated with clinically

significant distress or impairment in social, school, or other important areas of functioning (American Psychiatric Association, 2013).

Valid information on the prevalence of childhood GD is not available yet due to the absence of formal prevalence studies. An estimate of the prevalence of gender nonconforming/gender variant behaviours can, however, be made on the basis of studies where the Child Behavior Checklist (CBCL) (Achenbach & Edelbrock, 1983) was used. On the CBCL – a parent-report questionnaire on behavioural problems – two items are related to gender variance: Item 5 ('Behaves like opposite sex') and item 110 ('Wishes to be of opposite sex'). Information from the Dutch normative sample of the CBCL shows that in children, both items are more frequently endorsed by parents of girls than of boys; 'Behaves like opposite sex' in 2.6% of the boys and 5.0% of the girls, 'Wishes to be of opposite sex' in 1.4% of the boys and 2.0% of the girls (Verhulst, van der Ende, & Koot, 1996). These findings are in concordance with data from the normative sample of the CBCL in North-America (Achenbach & Edelbrock, 1981; Zucker, Bradley, & Sanikhani, 1997), and are largely replicated in a study of Dutch twins ($N=23,393$) at ages 7 and 10 (Van Beijsterveldt, Hudziak, & Boomsma, 2006). Therefore, gender variance/gender nonconformity seems to be present in a small percentage of children and is more prominent in girls than in boys.

Interestingly, from what we know about the referrals to specialized gender identity clinics, the sex ratios for referred prepubescent children have always been in favour of natal men, which may be a direct effect of a difference in increased acceptance of masculinity in girls compared to femininity in boys (e.g. Blakemore, 2003; Cohen-Kettenis et al., 2003; Steensma et al., 2014; Wallien, Veenstra, Kreukels, & Cohen-Kettenis, 2010; Zucker, Wilson-Smith, Kurita, & Stern, 1995). Over the last decades the reported sex ratios have, however, gradually changed. For example, in the period before 2000 the ratio between boys and girls was 5.75:1 in Canada and 2.93:1 in the Netherlands (Cohen-Kettenis et al., 2003). In the period after 2000, the sex ratios decreased in Canada to 3.41:1 (2008–2011) for boys and girls respectively (Wood et al., 2013); and a similar pattern was observed in the Netherlands with a sex ratio of 1.68:1 between 2008 and 2011 (Steensma, 2013). For both countries this change in ratios is caused by fewer referrals of boys. Although empirical evidence is currently not available, the decrease of referrals in boys may indicate an increasing tolerance over time towards gender nonconforming behaviours in both countries.

Psychological functioning, social tolerance, and other co-existing problems

Besides the gender nonconforming presentation, children with GD who are referred to clinical settings have been shown to be more psychologically vulnerable in comparison to non-referred controls (Bates, Bentler, & Thompson, 1973, 1979) and in comparison to the general population (e.g. Cohen-Kettenis et al., 2003; Singh, Bradley, & Zucker, 2011; Steensma et al., 2014). Furthermore, these studies show that these psychological problems are more of an internalized nature (such as depression, social withdrawal, and anxiety), instead of an externalizing nature (such as aggression) (Bates et al., 1973, 1979; Coates & Person, 1985; Rekers & Morey, 1989; Zucker & Bradley, 1995; Cohen-Kettenis et al., 2003; Steensma et al., 2014). However, as Zucker, Wood, and VanderLaan (2014) recently concluded from their summary of studies reporting on the psychological functioning of gender-referred children, there is a considerable variability across the different studies. For example, the percentage of clinical-range cases reported in studies using the total behaviour problem score of the CBCL, ranged from 12.5% up to 84% of the described children over the different studies (for an overview see Zucker et al., 2014).

To understand this association between GD and the variability of psychological functioning within the population of children with GD, the empirical literature indicates the effect is largely mediated through social (in)tolerance towards gender nonconformity/gender variance. Indeed, a wide range of studies in children from the general population showed that gender nonconforming behaviour is often evaluated negatively by other children (e.g. Carter & McCloskey, 1984; Levy, Taylor, & Gelman, 1995; Ruble et al., 2007; Signorella, Bigler, & Liben, 1993; Stoddart & Turiel, 1985). Peer relations in general are therefore poorer for clinically referred children with GD than for non-referred children/youth (e.g. Cohen-Kettenis et al., 2003; Zucker et al., 1997, 2012); and, as we might expect, poor peer relations are associated with a negative well-being and poor psychological functioning in children with GD (e.g. Cohen-Kettenis et al. 2003; Steensma et al., 2014). Consequently the variability in psychological functioning detailed within the literature is likely inversely correlated with the intensity of social intolerance experienced by the children with GD. For example, a cross-national study between children referred for their gender from Canada and from the Netherlands showed a much higher prevalence of emotional and behavioural problems in the Canadian children than in the Dutch children. Interestingly, quality of peer relations rather

than IQ, parental social class, marital status, or ethnicity, turned out to be the strongest predictor in both countries. Furthermore, the quality of peer relations was lower in Canada than in the Netherlands. This indicates that psychological functioning is highly dependent upon how gender nonconformity is accepted within a certain culture or environment (Steensma et al., 2014).

However, this may not be the only factor that results in poorer psychological functioning. Over the years other models postulated in the literature focused, for example, upon generic risk factors for psychopathology and behavioural problems (such as parental psychopathology, social class background) in relation to GD; and considered them as an inherent cause of psychological problems in children with GD. Evidence for these relations is, however, still scarce and both models are under-studied in comparison to other factors such as social (in)tolerance (Zucker et al., 2014).

As far as co-occurring problems in children with GD are concerned, the relationship between Autistic Spectrum Disorders (ASD) and GD is important to mention. Although there are few studies investigating the relationship between the two, one study by de Vries, Noens, Cohen-Kettenis, van Berckelaer-Onnes, & Doreleijers (2010) showed that in a sample of 108 gender-referred children ASD was present in 6.4% of the children. This is significantly higher than the prevalence of 0.6–1% of ASD in the general population (Fombonne, 2005). Corresponding with these findings, a study by VanderLaan et al. (2015) of children referred for gender studied obsessional interests – which may be an indication of ASD – and showed that obsessions were more frequently reported by children referred for their gender in comparison with the general population. With regard to how ASD and GD are related, the question arises as to whether GD is an expression of ASD, or whether ASD is a symptom of GD; alternatively, of course, the two may be present without being related to each other (see van der Miessen et al., this issue).

Psychosexual development and related factors for persistence of GD

A central question in the counselling of children with GD is what their psychosexual outcome will be. Will the child grow up and identify as a gay man, lesbian woman, bisexual man or woman, or heterosexual man or woman without experiencing feelings of gender incongruence which require any intervention; or will the child need medical treatment in the future because the gender dysphoric feelings will persist and further intensify?

To date, there are 10 prospective follow-up studies described in the literature, together reporting on 317 gender nonconforming children who were followed-up in adolescence or early adulthood. The follow-up information in Zucker & Bradley (1995) is not included in this summary. In personal correspondence with Dr. Zucker it became clear that the 45 cases described are also included in the samples of Drummond, Bradley, Peterson-Badali, & Zucker (2008) (5 natal girls) and Singh (2012) (40 natal boys).

The conclusion from these studies is that childhood GD is strongly associated with a lesbian, gay, or bisexual outcome and that for the majority of the children (85.2%; 270 out of 317) the gender dysphoric feelings remitted around or after puberty (see Table 1).

However, there may be a number of arguments to nuance this high percentage of desistence. As is shown in Table 1 there is much variation in the reported persistence rates between the studies, ranging from 2% to 39%. Interestingly the studies before the year 2000 reported much lower persistence rates in comparison to the more recent studies after the year 2000. Furthermore, the persistence rates reported in two Canadian studies (Drummond et al., 2008; Singh, 2012) were identical (12%) but clearly lower in comparison to the follow-up study by Wallien & Cohen-Kettenis (2008) from the Netherlands. The explanation for these differences may be threefold:

First, the variation in intensity of GD in the children included differs across studies: The lower persistence rates in the earlier studies, compared to the more recent studies after 2000, may be the result of the inclusion of less extreme cases in the earlier studies than in later studies. For example, before the publication of DSM-III in 1980 there was no formal diagnosis of GD for children (Drescher, 2014). It could therefore be that the children included in the studies before 1980 would in retrospect not meet the full criteria for a diagnosis. Also, the recent

Table 1. Follow-up studies in children with GD.

Study	Sample	Age at follow-up (range)	Persistence rate
Bakwin (1968) Lebovitz (1972) Zuger (1984) Money & Russo (1979) Davenport (1986) Kosky (1987)	55 natal boys	13–36	9% (5 out of 55)
Green (1987)	44 natal boys	19 (14–24)	2% (1 out of 44)
Drummond et al. (2008)	25 natal girls	23 (15–37)	12% (3 out of 25)
Wallien & Cohen-Kettenis (2008) Singh (2012)	40 natal boys 14 natal girls 139 natal boys	19 (16–28) 21 (13–39)	39% (21 out of 54) 12% (17 out of 139)

studies consisted of clinically referred samples of children, which was not the case for the earlier studies. For example, in the study by Green (1987) the sample of feminine boys was recruited through advertisement.

Secondly, and in line with the intensity explanation, there are possible cultural differences in referral: As described earlier, the sex ratios of child referrals in Canada are historically in greater favour of boys than girls as compared to the Netherlands. This may indicate that femininity in boys is experienced as more problematic in Canada –resulting in more referrals of boys with less extreme GD than in the Netherlands. As a result, the persistence rates are higher in the Netherlands compared to Canada.

Thirdly, we can consider the time of follow-up: As can be seen in Table 1, the time of follow-up differed across the studies and one could hypothesize that the studies with a later follow-up age (of older adolescents or adults) and those having a longer follow-up time, would report higher persistence rates than the studies where the follow-up took place at a younger age (i.e. shorter follow-up time). This trend is however not observed over the reported studies. To test this hypothesis, Steensma & Cohen-Kettenis (2015) recently published a report on the first 150 childhood cases from Amsterdam, the Netherlands, and checked whether a longer follow-up period would result in higher persistence rates. The children were at the time of first assessment – between 5 to 12 years old and between 19 to 38 years of age at the time of follow-up. Out of the 150 cases, 40 re-entered the clinic during adolescence (12–18 years of age) and turned out to be persisters (26.7%). However, after checking the files of the adult clinic (which sees nearly all adults with gender dysphoria in the Netherlands), it appeared that five individuals applied for treatment after the age of 18, raising the persistence rate to 30% and showing the importance of long-term follow-ups. Based on this information, it seems reasonable to conclude that the persistence of GD may well be higher than 15%. However, desistence of GD still seems to be the case in the majority of children with GD.

Two other clinically relevant questions are (1) whether we know anything with regard to the factors that are associated with the persistence or desistence of childhood GD and (2) how the process of persistence or desistence is experienced.

As to the factors associated with the persistence of GD, knowledge is still limited but fortunately slowly increasing. A central finding from all quantitative studies focusing on the topic is that the persistence of GD is most closely linked to the intensity of the GD in childhood and the amount of reported cross-gendered behaviour; in other words the more intense GD is in

childhood, and the more cross-gendered behaviour is reported by parents or through self-report, the higher the chance that the GD persists (Drummond et al., 2008; Singh, 2012; Steensma, McGuire, Kreukels, Beekman, & Cohen-Kettenis, 2013; Wallien & Cohen-Kettenis, 2008). In addition to this, several other factors are linked to persistence of GD: For example, Steensma et al. (2013) and Wallien & Cohen-Kettenis (2008) showed that the persistence rate is generally higher in natal girls than in natal boys; And Steensma et al. (2013) and Singh (2012) found that the assessment age in childhood was higher in children where the GD persisted than for desisters; Further, Singh (2012) reported a higher social class in the parents of desisters compared to the parents of persisters.

In addition, Steensma et al. (2013) found that a social transition in childhood, especially in natal boys, and verbal identification with the desired/experienced gender was predictive for the persistence of GD. Interestingly, the identification finding was reported in an earlier qualitative study by Steensma, Biemond, de Boer & Cohen-Kettenis (2011) who observed differences in reported experiences of GD between persisters and desisters who were interviewed. For example, the persisters explicitly indicated that they felt they *were* the 'other' sex and the desisters indicated that they only *wished* they were the 'other' sex. The primary aim of the Steensma et al. (2011) study was to get a better understanding of the processes that contribute to the persistence and desistence of childhood GD. By interviewing adolescents (14 persisters, 11 desisters) who all fulfilled the DSM-IV or DSM-IV-TR criteria of a gender identity diagnosis in childhood (APA, 1994, 2000), it became clear that the period between 10 and 13 years was considered crucial. Both persisters and desisters stated that the changes in their social environment, the anticipated and actual feminization or masculinization of their bodies, and the first experiences of falling in love and sexual attraction in this period, contributed to an increase (in the persisters) or decrease (in the desisters) of their gender related interests, behaviours, and feelings of gender discomfort.

Treatment and counselling of children with GD

Over the last decade, the care for prepubescent children with GD has been rapidly changing and there is a growing number of specialized gender clinics for young people (Hsieh & Leininger, 2014; Khatchadourian, Ahmed, & Metzger, 2014; Riittakerttu, Sumia, Työläjärvä, & Lindberg, 2015). Best clinical practice in gender referred children is still controversial and raises debates among dedicated professionals. General agreement does, however, exist that the care for children with

GD should be focused on reducing the child's distress related to their GD; on help with other psychological difficulties; and optimizing psychological adjustment and wellbeing (e.g. Byne et al., 2012; Coleman et al., 2011). As for the counselling of the gender dysphoric feelings in children with GD; empirical treatment models do not exist and general consensus between clinicians is not always easy to obtain (Byne et al., 2012). In the current professional literature, three treatment models for the care of gender variant children can be distinguished (e.g. Byne et al., 2012; Drescher, 2013) and it is these to which we now turn.

The first approach focuses on working with the child and caregivers to lessen cross-gender behaviour and identification, to persuade the child that the 'right gender' is the one assigned at birth (Giordano, 2012), to decrease the likelihood that GD will persist into adolescence, and prevent adult transsexualism. Critics of this approach have linked it to 'reparative therapy', a term more commonly used to describe efforts to change same sex attraction to heterosexuality in gay adults or 'pre-homosexual' children (Drescher, 2013). In the past, such behavioural and psychodynamic therapies to lessen the GD have been largely used in children with GD with overall unsatisfactory results (Byne et al., 2012; Möller, Schreier, Li, & Romer, 2009). Instead, children often seem to become distressed if their preferences and/or behaviours are blocked (Richardson, 1999). At present, interventions aimed to lessen GD are referred to as unethical by the World Professional Association for Transgendered Health (WPATH: Coleman et al., 2011) and many other international professional organizations. The American Academy of Child & Adolescent Psychiatry, for example, has explicitly formulated their position against any psychological treatment aimed to change gender nonconforming behaviours (Adelson, 2012).

The second approach is focused on dealing with the potential social risks for the child (Byne et al., 2012). Because its aim is to allow the progress of the GD in the child to unfold in a natural way, it is often referred to as 'watchful waiting' (Drescher, 2013). Counselling based on this approach may include interventions that focus on the co-existing problems of the child and/or the family; helping parents and the child to bear the uncertainty of the child's psychosexual outcome; and providing psycho-education to help the child and the family to make balanced decisions regarding topics such as the child's coming out, early social transitioning, and/or how to handle peer rejection or social ostracism. In practice, the child and parents are encouraged to find a balance between an accepting and supportive attitude toward GD, while at the same time protecting the child against

any negative reactions and remaining realistic about the chance that GD feelings may desist in the future. Parents are encouraged to provide enough space for their child to explore their gender dysphoric feelings, while at the same time keeping all future outcomes open (e.g., de Vries & Cohen-Kettenis, 2012; Di Ceglie, 1998, 2014).

The third approach is focused on affirming the child's (trans)gender identification and helps the child to build a positive self-identity and gender resilience. In particular, the child is supported in transitioning to the desired/experienced gender role. The rationale for supporting social transition before puberty is that children can revert to their originally assigned gender if necessary since the transition is solely at a social level and without medical intervention (e.g. Byne et al., 2012; Drescher, 2013; Hill, Menvielle, Sica, & Johnson, 2010). Critics of this approach believe that supporting gender transition in childhood may indeed be relieving for children with GD but question the effect on future development. The debate thereby focuses on whether a transition may increase the likelihood of persistence because, for example, a child may 'forget' how to live in the original gender role and therefore will no longer be able to feel the desire to change back; or that transitioned children may repress doubts about the transition out of fear that they have to go through the process of making their desire to socially (re)transition public for a second time (Steensma, 2013). The fact that transitioning for a second time can be difficult was indeed shown in the qualitative study by Steensma et al. (2011) where children who transitioned early in childhood reported a struggle with changing back to their original gender role when their feelings desisted, with the fear of being teased or excluded by their peers reported as the main reason for this.

Unfortunately, empirical answers about the best way to counsel children with GD and their caregivers are currently not available. The WPATH have therefore formulated a balanced position in their Standards of Care (Coleman et al., 2011), where clinicians are encouraged to help families by providing information about what is known about the development of children with GD and to help them to make decisions where the potential benefits and challenges of particular choices are weighted.

Conclusion

According to the DSM-5 diagnostic criteria for gender dysphoria, children with GD experience clinically significant distress because of the incongruence between their assigned gender at birth and experienced gender (APA, 2013). The clinical presentation of children who

present with gender identity issues is characterized by gender-nonconformity and a vulnerability to having psychological problems – primarily of an internalized nature (e.g. Cohen-Kettenis et al., 2003; Steensma et al., 2014), and an increased likelihood of ASD symptomatology (de Vries et al., 2010; VanderLaan et al., 2015). The extent and intensity of all three characteristics can be variable.

When considering the development of children with GD; studies show that gender dysphoric feelings eventually desist for the majority of children with GD, and that their psychosexual outcome is strongly associated with a lesbian, gay, or bisexual sexuality which does not require any medical intervention, instead of an outcome where medical intervention is required (e.g. Drummond et al., 2008; Wallien & Cohen-Kettenis, 2008; Singh, 2012). Factors predictive for the persistence of GD have been identified on a group level, with higher intensity of GD in childhood identified as the strongest predictor for a future gender dysphoric outcome (Steensma et al., 2013). The predictive value of the identified factors for persistence are, however, on an individual level less clear cut, and the clinical utility of currently identified factors is low.

Taken together this shows that there can be a great variability with regard to presentation of children with GD and their psychosexual outcome. The counselling of children with GD can therefore be complex and clinically challenging. To date, there is general agreement that the care for children with GD should not be aimed at avoiding adult same sex attraction or transsexualism; that no medical intervention should be provided in childhood (before puberty); that counselling should therefore be focused on reducing the child's distress related to the GD, on help with other psychological difficulties, and on optimizing psychological adjustment and wellbeing (e.g. Byne et al., 2012; Coleman et al., 2011).

However, besides these basic clinical values, there is currently no general consensus about the best approach to dealing with the (uncertain) future development of children with GD, and making decisions that may influence the functioning and/or development of the child – such as a social transition. Different clinical approaches are presented in the literature, and indeed taking the variability in presentation of children with GD into account, it seems important to underline that a 'one size fits all' approach is not best practice for children with GD. Therefore, different kinds of treatment options should be available which respect the unique needs of every child. In particular, the child's clinical psychological profile and gender development, as well as the contextual psychosocial characteristics of the child's

family (e.g. belief system, supportive behaviours, access to health care) should always be taken into account in order to make balanced decisions. Currently, the limited empirical evidence in favour of a particular treatment makes treatment of teenagers with GD a controversial issue that raises intense, and often polarized, debate. Therefore, studies comparing different psychological treatment options are needed as well as research which aims to identify the factors involved in the persistence process of GD on an individual level. The primary goal is therefore to determine the safest and most efficacious mental and medical approach for the individual child with GD.

Declaration of interest

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

References

- Achenbach, T.M., & Edelbrock, C.S. (1981). Behavioral problems and competencies reported by parents of normal and disturbed children aged four through sixteen. *Monographs of the Society for Research in Child Development*, 46(1), Serial No.188.
- Achenbach, T.M., & Edelbrock, C.S. (1983). *Manual for the child behavior checklist and revised child behavior profile*. Burlington, VT: University of Vermont, Department of Psychiatry.
- Adelson, S.L. (2012). Practice parameter on gay, lesbian, or bisexual sexual orientation, gender nonconformity, and gender discordance in children and adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 51, 957–974.
- American Psychiatric Association. (1994). *Diagnostic and statistical manual of mental disorders* (4th ed.). Washington, DC: American Psychiatric Press.
- American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disorders* (4th ed., text rev.). Washington, DC: American Psychiatric Press.
- American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders* (fifth edition). Washington, DC: American Psychiatric Press.
- Bakwin, H. (1968). Deviant gender-role behavior in children: Relation to homosexuality. *Pediatrics*, 41, 620–629.
- Bates, J.E., Bentler, P.M., Thompson, S.P. (1973). Measurement of deviant gender development in boys. *Child Development*, 44, 591–598.
- Bates, J.E., Bentler, P.M., Thompson, S.P. (1979). Gender-deviant boys compared with normal and clinical control boys. *Journal of Abnormal Child Psychology*, 7, 243–259.
- Blakemore, J. E. O. (2003). Children's beliefs about violating gender norms: Boys shouldn't look like girls, and girls shouldn't act like boys. *Sex Roles*, 48, 411–419.
- Byne, W., Bradley, S.J., Coleman, E., Eyler, A.E., Green, R., Menvielle, E.J., ... Tompkins, D.A. (2012). Report of the American Psychiatric Association Task Force on Treatment

- of Gender Identity Disorder. *Archives of Sexual Behavior*, 41, 759–796.
- Carter, D.B., & McCloskey, L.A. (1984). Peers and the maintenance of sex-typed behavior: The development of children's conceptions of cross-gender behavior in their peers. *Social Cognition*, 2, 294–314.
- Coates, S., & Person, E.S. (1985). Extreme boyhood femininity: Isolated behavior or pervasive disorder? *Journal of the American Academy of Child Psychiatry*, 24, 702–709.
- Cohen-Kettenis, P.T., Owen, A., Kaijser, V.G., Bradley, S.J., & Zucker, K.J. (2003). Demographic characteristics, social competence, and problem behavior in children with gender identity disorder: A cross-national, cross-clinic comparative analysis. *Journal of Abnormal Child Psychology*, 31, 41–53.
- Coleman, E., Bockting, W., Botzer, M., Cohen-Kettenis, P., DeCuypere, G., Feldman, J., ... Zucker, K. (2011). Standards of care for the health of transsexual, transgender and gender non-conforming people, version 7. *International Journal of Transgenderism*, 13, 165–232.
- Davenport, C.W. (1986). A follow-up study of 10 feminine boys. *Archives of Sexual Behavior*, 15, 511–517.
- de Vries, A. L. C., Noens, I.L., Cohen-Kettenis, P.T., van Berckelaer-Onnes, I.A., & Doreleijers, T. A. H. (2010). Autism spectrum disorders in gender dysphoric children and adolescents. *Journal of Autism and Developmental Disorders*, 40, 930–936.
- de Vries, A.L., & Cohen-Kettenis, P.T. (2012). Clinical management of gender dysphoria in children and adolescents: The Dutch approach. *Journal of Homosexuality*, 59, 301–320.
- Di Ceglie, D. (1998). Management and therapeutic aims with children and adolescents with gender identity disorders and their families. In: D. Di Ceglie & D. Freedman (Eds.), *A Stranger in my own body: Atypical gender identity development and mental health*. London: Karnac Books, pp. 185–197.
- Di Ceglie, D. (2014). Care for Gender-Dysphoric Children. In: B.P.C. Kreukels, T.D. Steensma, A.L.C. de Vries (Eds.), *Gender dysphoria and disorders of sex development: Progress in Care and Knowledge*. New York: Springer Science + Business Media, pp. 151–169.
- Drescher, J. (2013). Controversies in Gender Diagnoses. *LGBT Health*, 1, 10–14.
- Drescher, J. (2014). Gender identity diagnoses: History and controversies. In: B.P.C. Kreukels, T.D. Steensma, A.L.C. de Vries (Eds.), *Gender dysphoria and disorders of sex development: Progress in Care and Knowledge*. New York: Springer Science + Business Media, pp. 137–150.
- Drescher, J., Cohen-Kettenis, P., & Winter, S. (2012). Minding the body: situating gender identity diagnoses in the ICD-11. *International Review of Psychiatry*, 24, 568–577.
- Drummond, K.D., Bradley, S.J., Peterson-Badali, M., Zucker, K.J. (2008). A follow-up study of girls with gender identity disorder. *Developmental Psychology*, 44, 34–45.
- Fombonne, E. (2005). Epidemiology of autistic disorder and other pervasive developmental disorders. *Journal of Clinical Psychiatry*, 66(Suppl 10), 3–8.
- Giordano, S. (2012). *Children with gender identity disorder, a clinical, ethical and legal analysis*. London and New York: Routledge.
- Green, R. (1987). *The 'sissy boy syndrome' and the development of homosexuality*. New Haven, CT: Yale University Press.
- Hill, D.B., Menvielle, E., Sica, K.M., & Johnson, A. (2010). An affirmative intervention for families with gender variant children: Parental ratings of child mental health and gender. *Journal of Sex and Marital Therapy*, 36, 6–23.
- Hsieh, S., & Leininger, J. (2014). Resource list: Clinical care programs for gender-nonconforming children and adolescents. *Pediatric Annals*, 43, 238–244.
- Khatchadourian, K., Ahmed, S., & Metzger, D.L. (2014). Clinical management of youth with gender dysphoria in Vancouver. *The Journal of Pediatrics*, 164, 906–911.
- Kosky, R.J. (1987). Gender-disordered children: Does inpatient treatment help? *Medical Journal of Australia*, 146, 565–569.
- Lebovitz, P.S. (1972). Feminine behavior in boys: Aspects of its outcome. *American Journal of Psychiatry*, 128, 1283–1289.
- Levy, G.D., Taylor, M.G., & Gelman, S.A. (1995). Traditional and evaluative aspects of flexibility in gender roles, social conventions, moral rules, and physical laws. *Child Development*, 66, 515–531.
- Möller, B., Schreier, H., Li, A., & Romer, G. (2009). Gender Identity Disorder in Children and Adolescents. *Current Problems in Pediatric and Adolescent Health Care*, 39(5), 117–143.
- Money, J., & Russo, A.J. (1979). Homosexual outcome of discordant gender identity/role: Longitudinal follow-up. *Journal of Pediatric Psychology*, 4, 29–41.
- Rekers, G.A., & Morey, S.M. (1989). Relationship of maternal report of feminine behaviors and extraversion to clinician's rating of gender disturbance. *Perceptual and Motor Skills*, 69, 387–394.
- Richardson, J. (1999). Response: finding the disorder in gender identity disorder. *Harvard Review of Psychiatry*, 7, 43–50.
- Riittakerttu, K., Sumia, M., Työläjärvä, M., & Lindberg, N. (2015). Two years of gender identity service for minors: overrepresentation of natal girls with severe problems in adolescent development. *Child and Adolescent Psychiatry and Mental Health*, 9, 9–9.
- Ruble, D.N., Taylor, L., Cyphers, L., Greulich, F.K., Lurye, L.E. & Shrout, P.E. (2007). The role of gender constancy in early gender development. *Child Development*, 78, 1121–1136.
- Signorella, M.L., Bigler, R.S., & Liben, L.S. (1993). Developmental differences in children's gender schemata about others: A meta-analytic review. *Developmental Review*, 13, 147–183.
- Singh, D. (2012). A follow-up study of boys with gender identity disorder. Unpublished doctoral dissertation, University of Toronto.
- Singh, D., Bradley, S.J., & Zucker, K.J. (2011). Commentary on 'An Affirmative Intervention for Families with Gender Variant Children: Parental Ratings of Child Mental Health and Gender' by Hill, Menvielle, Sica, and Johnson (2010). *Journal of Sex and Marital Therapy*, 37, 151–157.
- Steensma, T.D. (2013). From gender variance to gender dysphoria: Psychosexual development of gender atypical children and adolescents. Dissertation, VU University, Amsterdam, the Netherlands.
- Steensma, T.D., Biemond, R., de Boer, F., & Cohen-Kettenis, P.T. (2011). Desisting and persisting gender dysphoria after childhood: A qualitative follow-up study. *Clinical Child Psychology and Psychiatry*, 16, 499–516.

- Steensma, T.D., & Cohen-Kettenis, P.T. (2015). More than two developmental pathways in children with gender dysphoria? *Journal of the American Academy of Child and Adolescent Psychiatry*, 54, 147–148.
- Steensma, T.D., McGuire, J.K., Kreukels, B.P., Beekman, A.J., & Cohen-Kettenis, P.T. (2013). Factors associated with desistence and persistence of childhood gender dysphoria: a quantitative follow-up study. *Journal of the American Academy of Child and Adolescent Psychiatry*, 52, 582–590.
- Steensma, T.D., Zucker, K.J., Kreukels, B. P. C., VanderLaan, D.P., Wood, H., Fuentes, A., & Cohen-Kettenis, P.T. (2014). Behavioral and emotional problems on the Teacher's Report Form: A cross-national, cross-clinic comparative analysis of gender dysphoric children and adolescents. *Journal of Abnormal Child Psychology*, 42, 635–647.
- Stoddart, T., & Turiel, E. (1985). Children's concepts of cross-gender activities. *Child Development*, 56, 1241–1252.
- Van Beijsterveldt, C.E., Hudziak, J.J., & Boomsma, D.I. (2006). Genetic and environmental influences on cross-gender behavior and relation to behavior problems: A study of Dutch twins at ages 7 and 10 years. *Archives of Sexual Behavior*, 35, 647–658.
- VanderLaan, D.P., Postema, L., Wood, H., Singh, D., Fantus, S., Hyun, J., ... Leef, J., (2015). Do Children With Gender Dysphoria Have Intense/Obsessional Interests? *Journal of Sex Research*, 52, 213–219.
- Verhulst, F.C., van der Ende, J., & Koot, H.M. (1996). *Handleiding voor de CBCL/4-18 [Manual for the CBCL/4-18]*. Erasmus University, Department of Child and Adolescent Psychiatry, Sophia Children's Hospital: Rotterdam, Netherlands.
- Wallien, M.S., & Cohen-Kettenis, P.T. (2008). Psychosexual outcome of gender-dysphoric children. *Journal of the American Academy of Child and Adolescent Psychiatry*, 47, 1413–1423.
- Wallien, M. S. C., Veenstra, R., Kreukels, B. P. C., & Cohen-Kettenis, P.T. (2010). Peer Group status of gender dysphoric children: A sociometric study. *Archives of Sexual Behavior*, 39, 553–560.
- Wood, H., Sasaki, S., Bradley, S.J., Singh, D., Fantus S., Owen-Anderson, A., & Singh, D. (2013). Patterns of referral to a gender identity service for children and adolescents (1976–2011): age, sex ratio, and sexual orientation. *Journal of Sex & Marital Therapy*, 39, 1–6.
- World Health Organization (1992). *International statistical classification of diseases and related health problems* (10th edition). Geneva: World Health Organization.
- Zucker, K.J., & Bradley, S. (1995). *Gender identity disorder and psychosexual problems in children and adolescents*. New York: Guilford Press.
- Zucker, K.J., Bradley, S.J., Owen-Anderson, A., Kibblewhite, S.J., Wood, H., Singh, D., & Choi, K. (2012). Demographics, behavior problems, and psychosexual characteristics of adolescents with gender identity disorder or transvestic fetishism. *Journal of Sex and Marital Therapy*, 38, 151–189.
- Zucker, K.J., Bradley, S.J., & Sanikhani, M. (1997). Sex differences in referral rates of children with gender identity disorder: Some hypotheses. *Journal of Abnormal Child Psychology*, 25, 217–227.
- Zucker, K.J., Wilson-Smith, D.N., Kurita, J.A., & Stern, A. (1995). Children's appraisals of sextyped behavior in their peers. *Sex Roles*, 33, 703–725.
- Zucker, K.J., Wood, H., & VanderLaan, D.P. (2014). Models of psychopathology in children and adolescents with gender dysphoria. In: B.P.C. Kreukels, T.D. Steensma, A.L.C. de Vries (Eds.), *Gender dysphoria and disorders of sex development: Progress in Care and Knowledge*. New York: Springer Science + Business Media, pp. 171–192.
- Zuger, B. (1984). Early effeminate behavior in boys. Outcome and significance for homosexuality. *Journal of Nervous and Mental Disease*, 172, 90–97.

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